PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2001-D18

DATE OF HEARING-
June 19, 2000

PROVIDER -
Interim Healthcare of Kansas City
Kansas City, KS

Provider No. 17-7087

Cost Reporting Periods Ended -
December 31, 1996 & December 31, 1997

vs.

INTERMEDIARY -
Blue Cross Blue Shield Association/ Cahaba Government Benefits Administrators

INDEX

ISSUES:

1. Was the Intermediary's adjustment to owner's compensation proper?

2. Was the Intermediary's adjustment to community liaison salary and benefits proper?

3. Was the Intermediary's adjustment to franchise fees proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Interim HealthCare of Kansas ("Provider") is a proprietary home health agency ("HHA") located in Kansas City, Kansas. Wellmark, Inc. ("Intermediary") reviewed the Provider's Medicare cost reports for the Provider's cost reporting periods ended December 31, 1996 and December 31, 1997. Based upon these reviews, the Intermediary made an adjustment reducing the amount of owner's compensation that would be allowed for program reimbursement in the Provider's 1996 reporting period. In addition, the Intermediary made adjustments disallowing the salary and benefits of the Provider's Community Liaison in both the 1996 and 1997 cost reporting periods, and an adjustment disallowing portions of weekly service fees paid by the Provider as part of its franchise agreement in its 1997 reporting period.

On September 29, 1998, the Intermediary issued a Notice of Program Reimbursement ("NPR") perfecting its adjustments to the Provider's 1996 cost reporting period, and on September 30, 1999, the Intermediary issued an NPR perfecting the subject adjustments made to the Provider's 1997 cost report. On March 25, 1999, and January 14, 2000, respectively, the Provider appealed the Intermediary's adjustments to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835.-1841, and met the jurisdictional requirements of those regulations.1 The amount of program funds in controversy is approximately $114,000 in 1996, and approximately $91,500 in 1997.2

The Provider was represented by Christopher L. Keough, Esq., of Powers, Pyles, Sutter, & Verville, P.C. The Intermediary was represented by James R. Grimes, Esq., Associate Counsel, Blue Cross and Blue Shield Association.

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[1] Provider=s Post Hearing Brief at 2. Note: Cahaba Government Benefits Administrators is now the Provider=s Intermediary.

[2] Intermediary=s Position Papers at 4.

ISSUE No. 1 - Owner's Compensation

FACTS:

The Provider claimed compensation expenses of $115,398 for the services of its owner who serves as the facility's president. The owner worked a total of 954 hours for the Provider during the subject cost reporting period while also working an average of 24 hours per week at another HHA which he owns, as well as 9 hours per week and 2 hours per week, respectively, at two other HHAs where he holds a 50 percent ownership interest.3

The Intermediary determined that $107,494 was a reasonable compensation level for the Provider's owner based upon data contained in the Homecare Salary &Benefits Report 1996-1997. The Intermediary also determined that the Provider's owner should not be considered a full-time employee, and that the amount of compensation that should be allowed for program reimbursement should be adjusted based upon the percentage of time the owner worked for the Provider in comparison to the total time he worked at each facility. Accordingly, the Intermediary made an adjustment reducing the Provider's owner's compensation to $36,548, which is 34 percent of the $107,494 amount derived from the Homecare report. The 34 percent was derived as follows:

Facility	Hours Worked/Week	Weeks/Year	Total Hours (%)
1.	24	x 52	1,248 (44.99 %)
2.	9	x 52	468 (16.87 %)
3.	2	x 52	104 (3.75%)
Provider			954 (34.39 %)
Total Hours Worked			2,774 (100%)

Subsequently, the Intermediary conceded that the total owner's compensation claimed by the Provider was a reasonable amount for a full-time employee. Therefore, the Intermediary is agreeable to allowing the Provider $39,685 in owner's compensation, i.e., $115,398 x 34.39 percent.4

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[3] Intermediary=s Position Paper, Case No. 99-2430, at 5. See Exhibit I-1 at 15.

[4] Intermediary=s Position Paper, Case No. 99-2430, at 6.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary's adjustment is improper. According to the Provider, the Intermediary never determined that the amount of compensation at issue in this case was unreasonable by comparing it to the compensation paid by similar institutions for similar services as required by program rules.5

The Provider explains that regulations at 42 C.F.R. § 413.102(b)(2) provide that reasonable compensation includes any amount ordinarily paid "for comparable services by comparable institutions." Id. Program instructions contained in the Provider Reimbursement Manual, Part I ("HCFA Pub. 15-1") § 904, provide further guidance, as follows:

> 904. CRITERIA FOR DETERMINING REASONABLE COMPENSATION-GENERAL
>
> In general, the determination as to the reasonableness of a person's compensation is made by comparing it with the compensation paid to other individuals in similar circumstances. To obtain uniformity in the application of the principle, the intermediary (1) identifies compensation paid to individuals other than owners by comparable institutions in the same geographical area, (2)furnishes this data to the Bureau of Health Insurance regional office where it is consolidated with data obtained by other intermediaries to produce ranges of reasonable compensation to be used in the same area, and (3) applies a set of criteria based on the qualifications and responsibilities of the owner to determine his placement within the range.

HCFA Pub. 15-1 § 904.

With respect to these requirements, the Provider points out that the Intermediary, admittedly, has not shown that the compensation paid to its owner was substantially out of line with the compensation cost incurred by any other HHA in the Provider's area, let alone an agency similar in size, scope of services, and utilization.6 Specifically, the Provider asserts that the Intermediary formulated its adjustment using salary ranges reflected in a Homecare Salary and Benefits Report while also considering data contained in the Michigan Survey. The Provider argues that the Intermediary's witness knew nothing about the Homecare Survey and admitted that there is no evidence in the record showing when the survey was conducted; who performed the survey; what the survey instrument asked for; what the responses said;

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5 Provider=s Post Hearing Brief at 42.

6 Transcript (ATr.@) at 239 and 242.

whether any of the survey respondents within a seven-state region were actually located in the same state as the Provider; or, the size of, or number of personnel employed by the institutions that were included in the survey sample. Thus, the Intermediary's witness conceded that he could not say that the Homecare Survey comprises a statistically valid basis for comparison with the Provider's owner's compensation.

Similarly, the Provider asserts that the Intermediary's witness admitted that the Michigan Survey is not a statistically valid basis for comparison with the compensation paid to the Provider's owner.7 That survey was conducted in the 1970s and included a sample comprised solely of outpatient physical therapy service providers ("OPT") in the State of Michigan. The Provider cites Call-A-Nurse, [1999-2 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 300,325 (invalidating the application of the Michigan Survey to disallow a home health agency's owner? s compensation costs incurred in fiscal years 1991-93 "because the OPT clinics studied in that survey were not comparable to [the provider] in size, organizational structure, type of services provided, personnel employed, or geographic area"); and, Stat Home Health Care, Inc. v. Blue Cross and Blue Shield Association, PRRB Dec. No. 96-D7, January 30, 1996, Medicare & Medicaid Guide (CCH) ¶44,011, decl'd rev., HCFA Admin., March 15, 1996, (reversing the disallowance of owner's compensation based upon "outdated, inappropriate, and inadequate" data).

The Provider also contends that the Intermediary failed to present competent evidence it possessed regarding compensation amounts paid by institutions in the Provider's area, and that such failure must result in a finding that the subject compensation amount is reasonable and fully allowable.8 The Provider argues that there is no dispute that the Intermediary has in its possession the HCFA Form 339 compensation data pertaining to all HHAs in the Provider's area during the subject cost reporting period.9 Also, there is no dispute that the Intermediary is obligated to periodically survey its provider data to account for changes in compensation levels, duties, and responsibilities of owners and administrators. HCFA Pub. 15-1 § 905.4.10 Further, the regulations governing Board proceedings explicitly state that "the intermediary shall ensure that all available documentary evidence in support of each party's position is part of the record." 42 C.F.R. § 405.1853(a).

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7 Exhibit I-1 at 20. Tr. at 233-238.

8 Provider=s Post Hearing Brief at 45.

9 Tr. at 241.

10 Tr. at 243.

Respectively, the Provider cites the Supreme Court's observation:

> [t]he production of weak evidence when strong evidence is available can lead only to the conclusion that the strong would have been adverse. . . . Silence then becomes evident of the most convincing character,

Interstate Circuit v. United States, 306 U.S. 208, 226 (1939)(emphasis added).

Moreover, the Provider refers to the "adverse inference" rule:

[s]imply stated, the [adverse inference] rule provides that when a party has relevant evidence within his control which he fails to produce, that failure gives rise to an inference that the evidence is unfavorable to him.

International Union v. NLRB, 459 F.2d 1329, 1336 (D.C. Cir. 1972).

The Provider explains that the adverse inference rule rests on the presumption that if a party chooses not to introduce relevant evidence in its possession then: "the evidence is unfavorable to the party." Id. at 1338. Moreover, the Provider asserts that the adverse inference rule is clearly applicable to administrative proceedings such as Board hearings: "[t]he argument for allowing all evidence to be admitted 'for what it is worth' in administrative proceedings thus cuts in favor of the adverse inference rule rather than against it." Id. at 1340.

The Provider contends that even if the Intermediary's determination of the Provider's maximum allowable owner's compensation was supported with substantial evidence, the Intermediary's attempt to prorate that compensation based upon total hours worked by the Provider's owner is invalid.[11] The Provider explains that the Intermediary allowed only 34 percent of the Provider's owner's compensation because the owner worked 954 hours for the Provider during the subject cost reporting period out of a total of 2,774 hours worked at all facilities. The Intermediary made this disallowance based upon its own interpretation of HCFA Pub. 15-1 § 904.2(c)(1). The Provider argues, however, that this approach is invalid for three reasons.

First, the Provider argues that the Intermediary's approach presumes that the duties the owner performed for the Provider were lesser in scope than the services furnished by other owners or administrators of comparable institutions in the area. However, the Provider asserts there is no evidence in the record to support that assumption. Conversely, the owner's job description shows that

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[11] Provider=s Post Hearing Brief at 47.

he is ultimately responsible for all aspects of the operations of the Provider.12

Second, the Provider argues that the Intermediary's approach contravenes the plain meaning and intent of the program to pay providers their reasonable cost. The intent of the reasonable cost provisions of the Social Security Act and the implementing regulations is to reimburse providers for the actual costs they incur in the efficient delivery of needed health services. See 42 U.S.C. § 1395x(v)(1)(A); 42 C.F.R. § 413.9. The Intermediary's method of evaluating the reasonableness of the subject owner's compensation, however, results in the disallowance of costs incurred in the efficient delivery of care. For example, if the subject owner had worked less efficiently and spent a greater number of hours furnishing the same level of service to the Provider, the Intermediary would have disallowed proportionately less of the actual cost incurred. Because the owner was able to discharge his duties in a more efficient manner, however, the Intermediary has disallowed most of the cost incurred for those services.

And third, the Provider argues that even assuming, arguendo, that the Intermediary may properly reduce reasonable compensation on an hourly basis, the Intermediary understated the hours worked by the Provider's owner in proportion to the average number of hours worked by a full-time employee. For purposes of evaluating the reasonableness of the compensation paid to the Provider's owner, the Intermediary effectively determined that he worked only 34 percent of the hours worked by a full-time employee. That percentage reflects the number of hours the owner worked specifically for the Provider (954) in proportion to the number of hours he worked in all endeavors during the year (2,774). However, the number of hours the owner worked on behalf of the Provider is approximately 53 percent of the average number of hours actually worked by a full-time employee. That is, data presented by the Health Care Financing Administration ("HCFA") reflects that full-time salaried employees typically work 1,808 hours per year, excluding paid time off. 63 Fed. Reg. 5106, 5114 (Jan. 30, 1998). The Provider adds that the Intermediary's application of its 34 percent determination is also invalid citing High Country Home Health, Inc. v. Shalala, [1999-1 Transfer Binder] Medicare & Medicaid Guide (CCH) § 300,173 (D. Wyo. 1999).

Finally, the Provider contends that even assuming the Intermediary's determination of the Provider's allowable compensation cost for the services furnished in 1996 is correct, the Intermediary's disallowance of the "excess" cost incurred in 1996 conflicts with pertinent regulations and manual instructions and is arbitrary and capricious.13 Specifically, the Provider points out that program instructions at HCFA Pub. 15-1 § 904, in accordance with 42 C.F.R. § 413.102(b)(2), acknowledge that an amount of owner's compensation that falls outside of an

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12 Exhibit P-8.

13 Provider=s Post Hearing Brief at 49.

established range of reasonable compensation may be allowed in "special circumstances." Respectively, the Provider asserts that the instant case clearly involves special circumstances.

The Provider explains that the evidence in this case shows that its owner's salary was reduced to $30,000 in its 1997 cost reporting period, and to zero for the next two reporting periods although he continued to work roughly the same number of hours for the Provider in each of those years as he had in 1996.14 Thus, the Provider asserts that his average annual compensation over that four-year period was only $36,250 per year, which is clearly reasonable even under the Intermediary's original determination. As a consequence, the Provider should be reimbursed for the full amount of the allegedly "excessive" compensation paid to Mr. Hess during 1996.

The Provider adds that under analogous Medicare reimbursement principles the "excess" cost incurred in its 1996 cost reporting period may be averaged over succeeding cost reporting periods. The Provider cites HCFA Pub. 15-1 § 2135.3.4 permitting management fees to be: "evaluated over more than one cost reporting period" so that excessive fees incurred in one year are averaged out with lower management fees incurred in prior or subsequent cost reporting periods); and, HCFA Pub. 15-1 ? 110.A.2 permitting the reasonableness of lease payments to be evaluated over the entire term of the lease. Concluding, the Provider argues that the Intermediary's failure to recognize and apply the same principle here is arbitrary and capricious. Transactive Corporation v. United States, 91 F.3d 232, 237 (D.C.Cir. 1996) (an agency must "conform its . . . policies to apposite existing regulations or offer 'reasoned analysis' for why actual differences . . . justify any conflict . . ; See also Cheshire Hospital v. New Hampshire-Vermont Hospitalization Service, Inc, 689 F.2d 1112, 1126 (1st Cir. 1982) (HCFA cannot apply one interpretation of a Medicare rule in some cases and a different interpretation in other cases).

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its adjustment reducing the Provider's owner's compensation is proper.15

The Intermediary contends that it determined the reasonableness of the subject compensation using "other appropriate means" pursuant to 42 C.F.R. § 413.102(c)(2), which states in part:

> [o]rdinarily compensation paid to proprietors is a distribution of profit. However, if a proprietor furnishes necessary services for the institution. . .reasonable compensation for these services is an allowable cost. If

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14 Tr. at 215.

15 Intermediary=s Position Paper at 6.

> services are furnished on less than a full-time basis, the allowable compensation should reflect an amount proportionate to a full-time basis. Reasonableness of compensation may be determined by reference to, or in comparison with, compensation paid for comparable services and responsibilities in comparable institutions, or it may be determined by other appropriate means.

42 C.F.R. § 413.102(c)(2) (emphasis added).

The Intermediary explains that program instructions at HCFA Pub. 15-1 ? 902.3 define reasonable compensation as the fair market value of services rendered by an owner in connection with patient care. And, that fair market value is determined by supply and demand factors of the open market. However, the Intermediary adds that there is no open market for positions like the Provider's president, as owners have the ability to establish their own compensation levels. Therefore, "other appropriate means" of determining reasonable owner's compensation must be used.

With respect to using total hours worked as the basis for prorating or adjusting the Provider's owner's compensation, the Intermediary refers to program instructions at HCFA Pub. 15-1 § 904.2(C)(1), which state in part:

> [c]ompensation for "full-time" service requires that at least 40 hours per week be devoted to the duties of the position for which compensation is requested. Owners devoting less than 40 hours per week to the position will be compensated on a proportionate basis, with 40 hours per week considered to be the full-time basis for such proportionate compensation.

HCFA Pub. 15-1 § 904.2(C)(1).

And, HCFA Pub. 15-1 904.2(D), which states:

> [w]hether the owner performs services for any other institutions or is engaged in any other occupation.

1. Presumably, where an owner performs services for several institutions, he spends less than full time (i.e., at least 40 hours a week) with each institution. In such cases, allowable compensation shall reflect an amount proportionate to a full-time basis.

> 2. If an owner is engaged in another activity, such as an owner-administrator also having a private medical practice, he ordinarily could not render full-time services as administrator of the institution.

HCFA Pub. 15-1 § 904.2(D).

Accordingly, the Intermediary explains that it used a base of 2,774 hours to allocate or adjust the subject owner's compensation as the Provider documented that its owner worked in excess of 2,080 hours.16 The Intermediary asserts that by using total hours worked it is trying to establish the reasonable compensation for the actual position held by the Provider's owner. The Intermediary asserts that salaried employees, or owners, are not paid an hourly rate but are compensated for the job itself.

The Intermediary also argues that when owners are engaged in activities outside of the agency it must look at the total time spent by the owner in order to properly account for the portion of his or her time spent on agency business. The Intermediary asserts that hours worked is the only method available to determine this allocation. The Intermediary also asserts this position is supported by the Board's decision in Home Health Concepts, Inc. v Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of South Carolina, PRRB Dec. No. 93-D58, July 19, 1993, Medicare and Medicaid Guide (CCH) ¶ 41,607, decl'd rev., HCFA Admin., September 9, 1993 ("Home Health Concepts"). According to the Intermediary, the provider in Home Health Concepts reported that its owner worked 40 hours per week for the agency and 15 to 20 hours per week at a pharmacy. The Board found that the owner's time was divided between the home health agency and the pharmacy and recommended a disallowance based upon the time the owner worked at the pharmacy in relation to the overall hours worked. In the instant case, the owner split his time performing administrative duties for related HHAs and his duties as the Provider's president. In using a base of 2,774 hours, the Intermediary applied the same principle of disallowing the time the owner spent on administrative duties for the related organizations in relation to his total time worked.

The Intermediary also asserts that adjusting the subject owner's compensation based upon total hours worked as apposed to 2,080 hours is supported by HCFA. In a letter dated August 5, 1999, HCFA explains that the allocation of an owner's administrative time based on total hours worked, instead of 2,080 hours, is an acceptable approach for adjusting administrative and general costs since it results in a more accurate allocation.17

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16 Intermediary=s Position Paper at 8. Intermediary=s Post Hearing Brief at 9

17 Exhibit I-7.

Finally, the Intermediary rejects the Provider's argument that its owner is equivalent to 53 percent of a full-time employee. The Intermediary explains that the Provider bases this argument using data reflecting that full-time employees typically work 1,808 hours per year (excluding paid time off), and the fact that its owner worked 954 hours for its facility. The Intermediary disagrees with this position for two reasons. First, Medicare regulations define a full-time employee as someone who works at least 40 hours per week (i.e., 2,080 hours per year). And second, because the use of total hours worked is a more reasonable approach than strictly applying 2,080 hours considering the Provider was able to document that its owner actually worked 2,774 hours at his various facilities.

ISSUE No. 2 - Community Liaison

FACTS:

The Provider established a Community Liaison position within its agency in 1994, and hired an individual to fill that position. Notably, the Community Liaison maintained contemporaneous time logs reflecting the duties she performed on a daily basis.18

The Intermediary reviewed the job description established by the Provider for the Community Liaison position during its audit of the Provider's 1996 cost reporting period, and determined that the individual was responsible for performing some nonreimbursable activities. The Provider, however, did not furnish sufficient records at the time of the Intermediary's audit to support an allocation of the Community Liaison's time between the allowable and nonallowable activities she performed. Therefore, the Intermediary effectuated an adjustment reclassifying 100 percent of the Community Liaison's costs to a nonreimbursable cost center.19

The Intermediary made a similar adjustment to the Provider's 1997 cost report reclassifying all of the Community Liaison costs to a nonreimbursable cost center; however, there were some slight differences. In its 1997 cost report, the Provider self disallowed approximately 20 percent of its Community Liaison costs to reflect any time spent by that individual performing duties not solely related to allowable Medicare activities. Also, the Intermediary did obtain and review a 4-week sample of the Community Liaison's time records. The Intermediary concluded, however, that the records were not detailed enough to support an allocation of the individual's costs between allowable and nonallowable functions.20

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18 Provider=s Post Hearing Brief at 31. Tr. at 146.

19 Intermediary=s Position Paper, Case No. 99-2430, at 10.

20 Intermediary=s Position Paper, Case No. 00-0769, at 13. Provider=s Post Hearing

Subsequent to each of the Intermediary's audits, the Provider furnished samples of its Community Liaison's time records. Specifically, the Provider furnished the Intermediary with a 12-week sample of the time records applicable to its 1996 cost reporting period, and an 11-week sample applicable to 1997. Based upon a review of this data, the Intermediary is now agreeable to allowing 18 percent of the Provider's Community Liaison costs in 1996 and 15 percent in 1997.21

PROVIDER'S CONTENTIONS:

The Provider contends that the evidence in this case shows that the Intermediary's adjustments reclassifying the costs of its Community Liaison to a nonreimbursable cost center are improper.22 The responsibilities of the Community Liaison were to educate the Provider's patients and answer their concerns about Medicare issues affecting them, to coordinate the intake of patients, and to perform liaison activities with the rest of the health care system.23 Moreover, the cost of these activities is clearly allowable pursuant to 42 C.F.R. § 413.9 which provides for the payment of actual direct and indirect costs of services that are appropriate and helpful to the development and operation of a provider, and HCFA Pub. 15-1 § 2136.1, which states:

> [c]osts of activities involving professional contacts with physicians, hospitals . . . and similar groups and institutions, to apprise them of the availability of the provider's covered services are allowable. Such contacts make known what facilities are available to persons who require such information in providing for patient care, and serve other purposes related to patient care, e.g., exchange of medical information on patients. . .

HCFA Pub. 15-1 § 2136.1.

Similarly, the Provider explains that the program's instructions acknowledge that the: "cost of coordination activities, which ease the patient's transition from hospital or SNF to the home under the care of an HHA, are allowable." HCFA Pub. 15-1 § 2113.1. And that: "[e]ducation and liaison

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Brief at 33.

21 Intermediary=s Position Paper, Case No. 99-2430, at 13. Intermediary=s Position Paper, Case No. 00-0769, at 16.

22 Provider=s Post Hearing Brief at 36.

23 Tr. at 146-158. See also Exhibit I-8 at 3, Case No. 99-2430.

activities permit the HHA to establish ties with the rest of the health care system" and that these "activities are allowable." HCFA Pub. 15-1 § 2113.

The Provider also contends that the evidence in this case shows that the Community Liaison's responsibilities were not geared to, and did not encompass the solicitation of patients. The Provider did not expect the Community Liaison to engage in marketing or solicitation of referrals and, in fact, the Provider was not seeking referrals of Medicare business during the periods at issue as evidenced by its declining number of home visits during those periods.24

Finally, the Provider argues that it diligently kept contemporaneous records to support its allowable Community Liaison costs for the 1996 and 1997 cost reporting periods. During these periods, the Community Liaison kept daily time logs which she signed under a certification that the entries on the logs are accurate and complete.25 Moreover, all of the time entries are classified by codes indicating the nature of the activity performed and are accompanied by brief narrative descriptions of the activity.

Significantly, the Provider asserts that none of the entries on the time logs are attributable to sales and marketing activities. This is because the Community Liaison was not hired to market or solicit patients or referrals, and the uncontroverted evidence in the record shows that if the Provider were trying to solicit referrals of Medicare patients it was certainly doing a very poor job.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its proposal to disallow 82 percent of the subject Community Liaison costs in the Provider's 1996 cost reporting period is proper, as is its proposal to disallow 85 percent in 1997.26 The Intermediary asserts that the Provider's Community Liaison spent those percentages of her time performing activities geared toward patient solicitation which are not reimbursable pursuant to HCFA Pub. 15-1 § 2113.2, which states:

> [c]osts incurred by an HHA for personnel performing duties in the hospital or SNF which are primarily directed toward patient solicitation are unallowable costs for Medicare reimbursement purposes. . . . Visits made by personnel to patients which have not yet been referred to the HHA (as evidenced by the patient's medical record) in order to

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24 Tr. 164, 173, 178, and 207.

25 Tr. 149-152. Exhibits P-11 and P-12.

26 Intermediary=s Post Hearing Brief at 6. See also Intermediary=s Position Paper, Case No. 99-2430 at 10, and Case No. 00-0769 at 13.

> persuade the patient to request the HHA's services are considered patient solicitation, as would visits to physicians to obtain referrals. Obtaining referrals by means of a cooperating hospital or SNF employee, or by reviewing patient records to identify potential patients for the HHA, are also considered patient solicitation. Any costs incurred for these activities are unallowable. These costs include not only the compensation and transportation costs of the HHA personnel engaged in the activity, but also any costs the HHA incurs for meals, entertainment, gifts, etc., given to influence these parties to refer the patients to the HHA.

HCFA Pub. 15-1 § 2113.2.

With respect to this matter, the Intermediary contends that a review of the Community Liaison's job description shows that she performs the following activities which are geared toward increasing the Provider's patient utilization:27

? Assess and identify community awareness of the home health agency.

? Develop and maintain working relationships with key contacts in health care institutions and community service organizations.

? Develop and provide educational programs for community groups designed to promote awareness of the home health agency's range of services.

? Plan and participate in health fairs.

? Participate in speaking engagements designed to increase awareness of home health services available.

Moreover, the Intermediary contends that a review of the time records maintained by the Community Liaison supports the percentages of the Provider's costs the Intermediary proposes to disallow. The Intermediary explains that the Provider's time keeping system utilizes an activity coding system which is accompanied by a narrative explanation written by the employee. With respect to the Provider's Community Liaison, the time records show some time charged to codes "140" and "150," which pertain to patient referral, scheduling coordination, etc., which are allowable. However, the majority of the Community Liaison's time, i.e., 82 percent in 1996 and 85 percent in 1997, is unallowable.28

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[27] Case No. 99-2430 at Exhibit I-8-3.

[28] Tr. at 192. Case No. 99-2430 at Exhibit I-11. Case No. 00-0769 at Exhibit I-11.

The Intermediary asserts that the Community Liaison routinely charged her time to code "200." This code is designated as "Community & Client Service Liaison Activities" which are not allowable. Moreover, the employee's written narratives routinely did not match the code, or did not clarify what kind of activity she had spent her time performing.29

The Intermediary also explains that there are 12 subcategories of code "200" activities. The Intermediary asserts that the following activities identified under code "200" are unallowable because they do not relate to patient care and appear to be geared toward increasing patient utilization:

225: Preparation for public education and consultation activities/presentations

230: Public education and consultation activities/presentations

235: Preparation for consumer education and consultation activities/presentations

240: Consumer education and consultation activities/presentations

245: Preparation for social service/community service/disease specific support group activities/presentations

250: Social service/community service/disease specific support group activities/presentations

In addition, the Intermediary asserts that some specific examples of the Community Liaison's nonallowable time include the following:

? On February 20, 1996, the Community Liaison charged 11/2 hours to the "200" code which related to a blood pressure clinic. There are several other instances where she spent time performing blood pressure clinics at various locations. Some of this time was charged to the "200" code while some of it is charged to code "230", Public education and consultation activities/presentations. Time spent on blood pressure clinics is nonallowable as it does not related to patient care.

? The Community Liaison charged time spent as "Office, daily prep and planning" under the "200" code. It would appear that the "600" code, Administrative & Management Procedures, would be a more accurate code for these activities. Since the "200" code (Community & Client Service Liaison Activities) appears to be for nonallowable services, the Intermediary considers any general office time spent on these activities also nonallowable.

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29 Id.

? There are several instances where only a location is written in the description of the activity (i.e., Grand Court III, Royal Oaks) and the time is assigned to the "200" code. Without a description of the activities actually performed at these locations, the Intermediary is unable to determine that the time is spent on reimbursable activities.

Similarly, the Intermediary testified that time spent at various retirement homes was charged to the "200" code with no accurate explanation of the visit. If the visit was for post referral intake there was a different more accurate code number that could have been used. Or, if the visit were for coordination of a specific patient's care there was a more accurate code that could have been used to describe the time spent.

The Intermediary cites Mother Francis Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Texas, PRRB Dec. No. 95-D16, January 11, 1995, Medicare and Medicaid Guide ("CCH") ¶ 43,037, rev'd., HCFA Admin., March 8, 1995, Medicare and Medicaid Guide ("CCH") ¶ 43,241("Mother Francis"), where the Administrator of HCFA found the subject public relations and community affairs expenses were not allowable. The Intermediary asserts that the nature of the expense disallowed in Mother Francis is similar to the activity in this appeal. In Mother Francis the Administrator stated: "[t]he programs at issue were designed and administered to involve and to educate the community at large. The services, which generally involved the distribution of health literature, screening tests, health maintenance activities, and activities to encourage an active lifestyle, were free and available to the general public. Many of these activities were at public locations, not connected in any way with the Provider's facility." Id. The Intermediary considers this quote as a factual presentation of the nonallowable activity in this appeal.

Finally, the Intermediary contends that the Provider bears the burden of proving that their Community Liaison costs are allowable, and that it has failed to do so.

ISSUE No. 3 - Franchise Fees

FACTS:

The Provider entered into a franchise agreement with Interim HealthCare, Inc. ("Interim") in 1975.[30] Under the terms of the agreement Interim provides a package of services to the Provider in return for an initial payment of $15,000 and an ongoing weekly service charge equal to 3 percent of the Provider's Medicare and Medicaid revenues, and 5 percent of its non-Medicare/Medicaid revenue.

During the subject cost reporting period the Provider paid $83,865 in weekly fees to Interim. For cost reporting purposes, the Provider charged $31,088 of these service fees to its Medicare reimbursable administrative and general ("A&G") cost center. The remaining $52,777 in service fees

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[30] Interim HealthCare, Inc. was originally known as Personnel Pool of America. See Exhibit P-41.

were charged to a non-reimbursable cost center which is allocated only to the Provider's non-reimbursable private duty and staffing services.

The Intermediary reviewed the Provider's weekly franchise fees and determined that only $32,160 of the total $83,865 paid to Interim should be allowed for cost reporting purposes. The basis of the Intermediary's disallowance is program instructions at HCFA Pub. 15-1 § 2135.4.B, which state in part:

> Unallowable Costs.--Rights to a logo, noncompetition clauses or exclusive franchise rights to a particular territory, promotion or sale of a franchise, etc., are not related to a provider? s patient care activities and, therefore, are not allowable.

HCFA Pub. 15-1 2135.4.B.
In general, the Intermediary concluded that the weekly service fees paid by the Provider to Interim include payment for both allowable and unallowable services. For example, the Intermediary points out that the franchise agreement grants the Provider the right to use Interim's trademarks, service marks and trade names, and grants the Provider an exclusive territory. In contrast, the Provider generally argues that these services were included in its initial $15,000 franchise payment, and that the weekly service fees paid to Interim reflect reasonable costs for allowable services.31

PROVIDER'S CONTENTIONS:

The Provider contends that the service fees it paid to Interim during the subject cost reporting period are reasonable and were incurred in an efficient and cost effective manner in the delivery of allowable home health services. The Provider explains that the service fees it pays to Interim had been reviewed several times since it began participating in the Medicare program and that they had always been allowed.32

The Provider contends that 42 U.S.C. §§ 1395f(b) and 1395l(a) provide for the payment of the lesser of its customary charges or its reasonable cost as determined under 42 U.S.C. § 1395x(v), which states in part:

> [t]he reasonable cost of any services shall be the cost actually incurred, excluding there from any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with

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31 Intermediary=s Post Hearing Brief at 2. Tr. at 58. See also Exhibit P-13.

32 Provider=s Post Hearing Brief at 12.

> regulations establishing the method or methods to be used, and the items to be included, in determining such costs . . . .

Id. (Emphasis added.)

The Provider contends that the regulations implementing the statutory provision for payment of reasonable cost are codified at 42 C.F.R. § 413.9. The Provider asserts that these regulations provide that reasonable cost includes all: :necessary and proper costs incurred" in furnishing "services covered under Medicare and related to the care of beneficiaries." Id. The regulations define "necessary and proper costs" to mean:

> costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. They are usually costs that are common and accepted occurrences in the field of the provider's activity.

42 C.F.R. § 413.9(b).

Moreover, the regulations provide that the statutory provision for payment of reasonable cost is intended to include the "actual costs" incurred for services that are appropriate and helpful in developing and maintaining patient care facilities and activities. 42 C.F.R. § 413.9(c)(2)-(3). The Provider explains that this standard is subject to just one limitation, that is: "if a particular institution's costs are found to be substantially out of line with other institutions in the same area that are similar in size, scope of services, utilization and other relevant factors." 42 C.F.R. § 413.9(c)(2). The Provider asserts that a long line of precedent construing the reasonable cost standard in 42 C.F.R. § 413.9 holds that an intermediary bears the burden of showing that a provider's actual costs are substantially out of line with comparable costs incurred by comparable providers in the same area for comparable services.33

The Provider contends that interpretative guidelines addressing the reasonableness of costs incurred for a package of administrative support services are set forth in HCFA Pub. 15-1 ? 2135 and Blue Cross and Blue Shield Association ("BCBSA") Administrative Bulletin 1401, 80.01. The manual explains that an intermediary may perform a componentized analysis of a package of administrative support services in order: "to provide the same assurance as can be provided in other situations by a comparison of services in the aggregate, that the total cost of the necessary services is not substantially out of line." HCFA Pub. 15-1 § 2135. Consistent with the substantially out of line standard established in 42 C.F.R. § 413.9(c)(2), the interpretative guidelines in BCBSA Administrative Bulletin 1401, 80.01 explain that an intermediary bears the burden of establishing the fair market value ("FMV") of a package of administrative support services based on statistically valid data reflecting current marketplace prices. The BCBSA guidelines further provide that the componentized analysis should be used only as a

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[33] See Provider=s Post Hearing Brief at 15 for applicable case citations.

scoping tool to identify costs that might be substantially out of line and should be isolated for further review.34

Respectively, the Provider contends that the Intermediary's disallowance is inconsistent with the reasonable cost standard established by statute and implementing regulations. The Provider claims there is no genuine dispute that the administrative support services it received from Interim were appropriate and helpful to the development and maintenance of its operations and patient care activities. Therefore, it is entitled to be reimbursed for the actual service fees claimed for 1997, subject to just one exception, the extent that its costs are shown to be substantially out of line with comparable costs incurred by comparable providers in the same area for comparable services. In that regard, the Provider asserts that the Intermediary concedes that no objective evidence in the record shows that the weekly service fees claimed by the Provider were substantially out of line with costs incurred by comparable providers in the same area for comparable services.35 See Memorial Hospital/Adair City, 829 F.2d at 118, GranCare, Inc., and Regency Health Services, Inc., v. Shalala, 93 F. Supp. 2d 24 (D.D.C. 2000) ("GranCare"), Vermilion Home Health Agency, [1990 Transfer Binder] Medicare & Medicaid Guide (CCH)
¶ 38,377 at 22,125, and Home Health Services of Greater Philadelphia, 530 F. Supp. at 1246 (E.D. Pa. 1982) ("Greater Philadelphia").

The Provider also contends that BCBSA Administrative Bulletin 1401, 80.01 defines "offsite support services" to include routine telephone calls and correspondence to assist a provider in the resolution of daily administrative issues.36 Moreover, BCBSA assigned a FMV of $26,000 to this category of service in 1980, based upon a market rate of $50 per hour for consulting services.37 The Intermediary now seeks to apply the same FMV to services rendered 17 years later, and insists that it should be applied not only to routine consultations in resolution of daily administrative issues, but to all services which are made available to all franchisees of Interim.38

The Provider asserts that the Intermediary cannot base its disallowance solely upon these arbitrary evaluation criteria. As noted above, the reasonable cost standard established under the statute and implementing regulations requires the Intermediary to show that the Provider's costs are substantially out of line based upon objective evidence. See, e.g., GranCare supra. Nothing in the statute or implementing regulations authorizes the Intermediary to simply declare what is a reasonable cost for the administrative support services obtained from Interim or to disallow the Provider's costs based upon an

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34 Exhibit P-16 at 3.

35 Tr. at 104 and 118.

36 Exhibit P-15 at 2.

37 Id.

38 Tr. at 95 and 121.

alleged lack of documentation for the FMV of those services.

The Provider asserts that its position is supported by decisions rendered in several cases. The Provider cites Greater Philadelphia, supra, where the court upheld the Board's reversal of the intermediary's disallowance of costs incurred by a provider (as a percentage of revenues) for management services. The Provider asserts that the disallowance at issue in that case, as in the instant case, was based upon the intermediary's subjective opinions as to the reasonable cost components of a package of services obtained from a contractor. In St. Joseph's Hospital v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 83-D104, July 5, 1983, Medicare and Medicaid Guide (CCH) ¶ 33,096, aff'd in part (concerning administrative fee issue), HCFA Admin., September 6, 1983, Medicare and Medicaid Guide (CCH) ¶ 33,424, the Board reversed the intermediary's disallowance of management fees equal to 4 percent of the provider's revenues. In that case, as in the instant case, the intermediary attempted to compute a disallowance based upon its estimates of the value of services furnished to the provider. In a decision that was affirmed by the HCFA Deputy Administrator, the Board ruled that the management fees were "reasonable and . . . fully allowable" under the substantially out of line limitation, noting that the intermediary had "failed to show that the management fees were unreasonable in comparison to those incurred by other comparable providers." Id. Medicare and Medicaid Guide (CCH) ¶ 33,096 at 10,510. And, in Interim HealthCare of New Haven, PRRB Dec. No. 2000-D1, October 14, 1999, Medicare and Medicaid Guide (CCH) ¶ 80,341, decl'd rev., HCFA Admin., November 30, 1999 ("New Haven"), the Board reversed the disallowance of part of the $213,000 in services fees paid to Interim by the New Haven provider in its 1994 cost reporting period. In that case, the Board ruled that the intermediary: "did not carry out a persuasive analysis of the FMV of the services rendered," finding that even applying "conservative FMV for the services delivered, the value of the services still exceeded the amount claimed by the provider. . . by far." Id. at 201,122.[39]

The Provider explains that in New Haven the Board also found that offsite support, consisting solely of routine telephone calls and daily corresponding on administrative matters, should be valued at $91,000. Id. Moreover: "at least the minimum amounts claimed by the provider for the following other tangible services should be included in the allowable costs, sexual harassment training. . .meetings, specialist visits and review of operations, memoranda, group health, operational and clinical manuals, yellow pages, and legal assistance." Id. In all, the Board rejected the intermediary's assertion that these other tangible items and services are folded into the category of offsite support services. Notably, the Board found that some value for other services such as human resources, group purchasing and national payor agreements, should also be included in the componentized analysis in addition to the usual 20 percent permitted for standby costs. Id.

In summary, the Provider asserts that the foregoing authorities clearly prohibit the Intermediary's disallowance of the weekly service fees paid to Interim in the Provider's 1997 cost reporting period. The Intermediary has not shown that the Provider's cost is substantially out of line with costs incurred by

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[39] See Provider=s Post Hearing Brief at 19 for additional case citations.

comparable providers in the same areas for similar services, nor has the Intermediary furnished any evidence that the Provider's costs are unreasonable.

The Provider also contends that the record in this case shows that the weekly service fees it paid to Interim are entirely reasonable for at least five reasons.[40] First, the Provider has strong incentives to keep its costs as low as possible because it is operated for profit and most of its patient care services are not reimbursed on a cost basis.[41]

Second, the Provider's total cost of visits, $859,140, is only 65 percent of the allowable cost limits promulgated by HCFA for the Provider's 1997 cost reporting period ($1,313,569).[42] In comparison with HCFA's cost limits, which are required by law to be set at 112 percent of the mean cost per visit for HHAs in the same area, the Provider saved the Medicare program in excess of $450,000 with respect to the services it furnished Medicare patients.

Third, the Provider's A&G cost per visit, which includes the subject weekly service fees, is far lower than the A&G cost per visit incurred by most HHAs in the Provider's area. The Provider's A&G cost per visit for 1997 is approximately $22.70. In comparison, an analysis of the costs incurred by 30 other HHAs in the Provider's area shows A&G costs per visit ranging from a low of $7 to a high of $292, with a median cost of $28 per visit. That analysis was performed by an independent certified public accounting ("CPA") firm based upon cost report data obtained from a HCFA database for fiscal year 1995, two years earlier than the year at issue.[43] Notably,
the Provider's allowable A&G cost per visit falls at only the 35th percentile of the range of the fiscal year 1995 A&G costs per visit reflected in the CPA firm's analysis. Moreover, the inclusion of the Medicare related service fees claimed by the Provider for 1997, $31,088,
would increase its A&G cost per visit by only $1.84. Thus, even with the inclusion of the service fees claimed for 1997, the Provider's A&G cost per visit is still well below the median cost per visit incurred by the other HHAs in its area.

Fourth, the Provider's cost is clearly reasonable in comparison to the costs incurred by other HHAs for similar services. The weekly service fee claimed by the Provider, as a percentage of gross revenues, is generally lower than the percentage fees charged by other franchise operations in the home health field. Indeed, the fees charged by other franchise organizations in the Provider's area are as much as four times higher than Interim's fees as a percentage of revenues.[44]

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[40] Provider=s Post Hearing Brief at 22.

[41] Tr. at 27.

[42] Exhibit P-6 (audited cost report, worksheet C, line 7, column 11 and line 14, column 11). Tr. at 48.

[43] Exhibit P-42. Tr. at 50.

[44] See Exhibits P-19, P-20, and P-21 at 8. Tr. at 48.

Fifth, the FMV of the services furnished by Interim to the Provider during 1997 is substantially greater than the actual cost incurred for those services. The Provider's componentized analysis shows that the FMV of just some of the services furnished during the period was $218,808.45

The Provider also contends that there is no dispute as to its receipt of offsite support services from Interim.46 And, as the Board found in New Haven, and as the Intermediary found with respect to the Provider's 1995 cost reporting period, the FMV of those services alone is at least $91,000. Further more, an independent study conducted by The Corridor Group ("TCG") shows that the hourly rates for consulting services in the home health field currently range from $150 to $200 per hour.47 Notably, applying an average rate of $175 per hour to BCBSA's 1980 estimate of the FMV for offsite support increases its value to $91,000.

Moreover, the Provider adds that it received other tangible services such as manual updates and a specialist's visit that must be included in the analysis of the FMV of the services rendered. Application of the $175 per hour average rate identified in the TCG study, which the Intermediary accepted for the Provider's 1995 cost reporting period, and conservative estimates of the time that would be required for someone else to produce those services for the Provider, demonstrates that the FMV of those services is quite substantial.48

The Provider contends that none of the weekly service fees paid to Interim are attributable to its franchise rights or any other nonallowable items or services.49 The Provider explains that it pays weekly service charges to Interim under section 19(b) of its franchise agreement in exchange for on-going administrative support services. A separate franchise fee was paid to Interim at the inception of the agreement, under section 19(a), for the Provider's franchise rights.50 Thus, the plain language of the agreement clearly reflects that the weekly service charges are attributable to the on-going provision of administrative support services.51

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45 See Exhibit I-3 at 7, 8, 14, 16, 36, 37, 44, 56, 83, 84. Tr. at 41, 61, 64, 70, 78, 82, and 127.

46 Tr. 82 and 127.

47 Exhibit P-22 at 7.

48 Exhibit P-31 at 205. Exhibit I-3 at 14, 16, 36, 37, 44, 56. Tr. at 43, 62, and 78.

49 Provider=s Post Hearing Brief at 25.

50 Exhibit P-41 at '' 19(a) and (b). Tr. at 32, 35, 53, and 105.

51 Tr. at 53 and 105.

The Provider refers to Black's Law Dictionary asserting that a franchise is defined as the: "right granted by the owner or trademark or trade name to engage in business or to sell a good or service in a certain area" and, thus, a "franchise fee" is defined as the "fee paid by a franchisee to a franchisor" for these "franchise rights." Black's Law Dictionary 629, 668 (7th ed. 1999). Accordingly, the Provider argues that the franchise rights granted to the Provider are not "services" in the ordinary sense of that word, and the "service charges" paid to Interim under section 19(b) of the agreement are not attributable to the franchise rights conferred upon the Provider. As the Board found in New Haven, there is no evidence that the service fees paid to Interim relate to franchise rights.52

The Provider contends that the Intermediary's disallowance is also improper because it conflicts with the way the Intermediary treated the subject franchise fees expense in all of the Provider's prior cost reporting periods. The Provider explains that it has been reimbursed the full amount of its franchise fees for each of its cost reporting periods dating back to 1981.53 Accordingly, the Provider asserts that the Intermediary's effort to treat the same costs differently in its 1997 cost reporting period than it has in the past is arbitrary and capricious.

The Provider asserts that administrative rules must be applied uniformly. Hooper v. National Transportation Safety Board, 841 F.2d 1150 (D.C. Cir. 1988). The courts have long held that an administrative agency's action is arbitrary and capricious when, as here, the agency "treats seemingly similar situations dissimilarly without explaining any relevant factual differences between the situations." Garrett v. FCC, 513 F.2d 1056 (D.C. Cir. 1975); see also Transactive Corp. v. United States, 91 F.3d 232 (D.C. Cir. 1996) (citing Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mutual Auto. Ins. Co, 463 U.S. 29, 57 (1983)); Greater Boston Television Corp. v. FCC, 444 F.2d 841, 852 (D.C. Cir. 1970), cert. denied, 403 U.S. 923 (1971); Airmark Corp. v. FAA, 758 F.2d 685, 691-92 (D.C. Cir. 1985); Local 777, Democratic Union 0rganization Committee v. NLRB, 603 F.2d 862, 872 (D.C. Cir. 1978).

Moreover, the Provider argues that the Intermediary itself admits that none of the subject costs would be deemed unallowable if the FMV of the services furnished equaled or exceeded the actual costs incurred by the Provider. Tr. at 139. Therefore, the Provider concludes that the Intermediary concedes that none of the costs should be attributed to unallowable items or services since, as discussed above, the FMV of the services rendered to the Provider exceeded its actual cost by far.

The Provider rejects the Intermediary's argument that royalty income it received from Interim should be offset against the service fees it paid during the subject cost reporting period.54 The Provider explains

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52 Exhibit P-32 at 201,122.

53 Provider=s Post Hearing Brief at 27. Tr. at 36.

54 Provider=s Post Hearing Brief at 29.

that Interim paid royalties in respect of revenues it earned on staffing services that it furnished to a General Motors plant in the Provider's franchise area. Interim paid these royalties because the Provider has the exclusive franchise right to furnish staffing services under the Interim name within the Provider's area. The Provider argues that the Intermediary's argument should be rejected for at least two reasons.55

First, the royalty income the Provider received does not relate to the service fees paid to Interim. The royalty payments relate to the franchise fee the Provider paid to Interim at the outset of the franchise agreement. The Provider acquired its exclusive territorial franchise rights through payment of the franchise fee. The service fees at issue in this case are not attributable to franchise rights.

And second, even assuming that the royalty income should be offset against the Provider's costs, it would not be appropriate to effect that offset against the portion of the Provider's fees claimed for Medicare reimbursement ($31, 088). Since the evidence shows that the royalty fees were made with respect to staffing services furnished to General Motors, the royalty income would be attributable to the Provider's private duty and staffing service rather than its home health operations.56

Finally, the Provider contends that the Intermediary=s determination is barred under the doctrines of collateral estoppel and res judicata.[57] The Provider explains that the Intermediary made this same adjustment to its 1995 Medicare cost report. The Provider=s appeal of that adjustment was scheduled to be heard by the Board on March 31, 1999, together with the New Haven case. However, minutes before the hearing was to begin the Intermediary settled the case by stipulating on the record that all of the service fees incurred by the Provider were reasonable and allowable based upon its determination that the FMV of support services obtained from Interim was at least $90,000.[58] The Intermediary chose not to defend its position and stipulated that the data it used to effect a disallowance of 1995 franchise fees expenses, and now for 1997, is invalid.

INTERMEDIARY=S CONTENTIONS:

The Intermediary contends that its adjustment reducing the amount of the Provider=s franchise fees expense is proper. The Intermediary asserts that the portion of the fees it disallowed clearly pertains to items and services that are not reimbursable.[59]

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55 Tr. at 40, 58, 80, and 84.

56 Tr. at 34, 40, and 79. Exhibit I-3 at 2.

57 Provider=s Position Paper at 33.

58 Provider=s Position Paper at 16. Exhibits P-30 and P-31.

59 Intermediary=s Post Hearing Brief at 2.

The Intermediary contends that it reviewed the subject franchise fees expense in accordance with HCFA Pub. 15-1 ' 2135. In part, the manual explains that purchased management and administrative support services are allowable costs if they are reasonable and necessary and relate to patient care. However, at HCFA Pub. 15-1 ' 2135.4, the manual explains that any costs related to services such as a provider=s rights to a logo, noncompetition clauses or exclusive franchise rights to a particular territory, promotion of a sale or franchise, etc., are not related to patient care and are, therefore, not allowable. Respectively, the Intermediary contends that a review of the franchise agreement entered into between the Provider and Interim clearly demonstrates that the Provider was receiving both allowable and non-allowable services. The franchise agreement grants the Provider the right to use Interim=s trademarks, service marks and trade names, and to utilize its good will. Further, the agreement grants the Provider use of trade secrets owned by Interim. The agreement also grants to the Provider an exclusive territory. In addition, Interim may, from time to time, develop advertising programs in which the Provider agrees to participate. These types of services relate to the value of the franchise rights, its name and reputation. Such costs are not related to patient care, and as a result are non-allowable.[60]

The Intermediary contends that it determined the extent the Provider=s franchise fees expense were not reasonable, or unallowable, following the approach contained in BCBSA Administrative Bulletin No. 1401, 80.01. Specifically, the Intermediary explains that the Provider furnished a componentized analysis of the services furnished or made available by Interim and the value of those services.[61] In turn, the Intermediary evaluated the FMV of each componentized service noting that certain franchise fee expenses may be allowable as long as they do not exceed the costs allowed for similar non-franchised institutions.[62] In addition, the Intermediary noted that 42 C.F.R. ' 413.24(a) requires providers to maintain adequate cost data, capable of verification by qualified auditors, to support their claimed costs.

The results of the Intermediary=s evaluation are as follows:[63]

Offsite Support

The Provider claimed a value of $91,000 for offsite support services furnished by Interim. The Intermediary asserts, however, that no documentation was submitted by the Provider to determine the FMV of the goods and/or services it received. The Intermediary=s allowance recognizes memoranda, manual revisions and updates, and other general services, which are provided to all Interim franchisees. The Provider was allowed $26,000 in allowable expenses based upon a market value of $50 per hour for 520 hours. The Intermediary notes that BCBSA=s Administrative Bulletin was primarily developed

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60 Id. Tr. at 91. Exhibit P-41.

61 Exhibit P-13

62 Id.

63 Intermediary=s Position Paper at 8.

to determine the market value of hospital full service management contracts; however, it can be used in reviewing any purchased management and administrative support services such as those under a franchise. The scope of service provided by a hospital management company is much more extensive in comparison to an HHA. Therefore, in the absence of auditable documentation, which would support the Provider having received a value greater than the Intermediary=s allowance, no additional allowance is appropriate.

Specialist Visits

The Provider claimed a value of $2,200 for specialist visits. The Intermediary determined a FMV of $800 for the services of the specialist using a market value rate of $100 per hour instead of the $150 hourly rate claimed by the Provider. The Intermediary disallowed an additional $1,000 for travel costs related to these visits, as the Provider did not furnish documentation for that cost.

Other Tangible Services

1. Workshops, Training, Meetings

The Provider claimed a value of $18,900 for training workshops and educational programs on a variety of topics. The Provider assigned a FMV of $1,800 per day for each seminar but was unable to provide any supporting documentation for the training sessions for which it claimed a value. Without any auditable documentation no reasonable cost determination can be made. Therefore, the Intermediary did not allow any costs for this tangible service provided by the franchisor.

2. Legal Assistance

The Provider claimed a value of $7,240 for legal services provided by the franchisor for legal representation at meetings with the Intermediary. The Intermediary asserts that the legal assistance it received is a component of offsite support services and is a part of the Intermediary=s annual allowance of $26,000 discussed above.

3. Insurance Administration

The Intermediary asserts that the insurance administration provided to all franchisees is also a component of offsite support services, and is included in the annual allowance of $26,000 allowed for that service.

4. Financial Statement Analysis

The franchisor=s review of financial statements assures an accurate calculation of franchise fees which benefits the franchisor and is of no value to the Provider. Further, the Provider claimed direct cost for financial services through salaries or purchased services. Also, Interim does not prepare the Provider=s financial statements it only reviews them. Moreover, the Provider has not furnished documentation to support that this service was actually performed.

5. Operational Manual Updates

The Provider claims that it received a value from the franchisor of $63,000 for 30 manual updates ($2,100 per update). The Intermediary contends that manual updates are prepared once by Interim and then provided to all of its franchise holders. The Provider has assigned a value to these services as if they were written for it alone. This approach produces a grossly inflated valuation. The Intermediary asserts that the manual updates provided to all franchisees are a component of offsite support services. Procedural manual revisions and updates are a part of the Intermediary's annual allowance of $26,000 for offsite support services provided by the franchisor.

Other Services, Intangible

According to the BCBSA componentized model, examples of other services, intangible, include access to national purchasing programs and resulting discounts, financing assistance, guaranteeing/consigning/providing loans, quality assurance and maintenance programs, provision of operational manuals, staffing efficiency programs, risk factors such as subordination of the management fee to other provider liabilities, and reputation of the management company for efficiencies and effectiveness. The Intermediary values intangible and standby services at 20 percent of the value of tangible services.

In summary, the Intermediary asserts that the Provider assigned a FMV of $218,808 for services it received from the franchisor while claiming only $83,865 in expenses. Even though the FMV of the services received exceeded the cost of the services claimed on the cost report, the Provider has not provided documentation to support the actual services received for the $83,865 claimed. Without auditable documentation to support the claimed costs, the Intermediary is unable to determine the allowability of these costs.[64]

The Intermediary refers to 42 C.F.R. ' 413.9 as requiring that all payments to providers be based upon the reasonable cost of services covered under the Medicare program and relate to the care of the beneficiaries. Reasonable cost includes all necessary and proper costs incurred in furnishing services. The regulation further defines necessary and proper costs as those that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities, and include both direct and indirect costs and normal standby costs. Moreover, the burden of maintaining adequate records and documentation to support the value and reasonableness of franchise fees, as required under 42 C.F.R. ' 413.24, clearly rests with the Provider. The Provider is responsible for furnishing sufficient evidence for any allowable services received from the franchisor. The minimum level of documentation that a franchisee is required to maintain in order to substantiate the reasonableness of the franchisee fees is a summary of the directly-valued services including supporting man-hour reports for any labor intensive services, such as legal, financial, and consulting. This documentation should be prepared by

[64] Intermediary=s Position Paper at 11.

the Provider, the franchisor, or both. Auditable supporting records for the claimed services must be made available to the Intermediary when requested. To date, the Provider has not done so.[65]

The Intermediary contends that the Provider=s arguments regarding the allowability of the subject franchise fees ignores the diminishing value of actual services provided by the franchisor.[66] The Provider in this appeal has been Medicare certified since the early 1980s. Most of the services provided by a franchisor may be valuable to the Provider in its initial phase of development. However, services subsequently provided by the franchisor are, in comparison, of lessor scope and value. How many times must the franchisor give guidance on insurance administration and yellow page advertising and consulting? The issue of duplication of services must also be considered when evaluating the reasonableness of franchise fees. To the extent the franchise fees duplicate the services furnished in-house by the Provider, these costs are not allowable according to HCFA Pub. 15-I ' 2135.4.B. The Provider claimed $18,541 in legal and accounting costs for services which were allegedly provided by the franchisor. The Provider also engaged the services of a consultant to defend the reasonableness and value it received for services provided by the franchisor. Why didn=t the franchiser, who provides management and consulting services, defend the allowability of the franchise fee charged to the Provider? The Intermediary believes the reason is because Interim makes no representation in its franchise agreement as to how much of the franchise fee will be reimbursable by Medicare. In August 1996, Interim attempted to convince HCFA that the franchise fees charged to all its franchisees were reasonable and allowable costs incurred by the provider in rendering patient care services. However, HCFA was not persuaded. See Exhibit I-7.

Finally, the Intermediary asserts that most of the cost incurred for franchise fees relates to the Provider=s right to use Interim=s trademark name, exclusive territorial protection, sales and marketing activities, and reputation. The cost of these activities is unrelated to providing services to Medicare beneficiaries and is not reimbursable.

In support its position, the Intermediary explains that Interim paid the Provider $23,316 during the subject cost reporting period as royalty income.[67] This payment was made because Interim serviced a national account located in the Provider=s service area. In order to enter and provide services in the Provider=s exclusive service area, Interim had to pay the Provider a percentage of the revenues earned on that national account. The Intermediary asserts that this payment clearly illustrates that Interim is providing an ongoing benefit to the Provider in the form of protection and enforcement of its exclusive territory. Moreover, that benefit is being provided each week of each year the franchise agreement is in force. In the instant case, Interim is compensating the Provider for any encroachment of its territory.

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65 Id.

66 Intermediary=s Position Paper at 12.

67 Intermediary=s Post Hearing Brief at 4. Tr. at 40 and 58.

However, if any other franchisee tried to enter the Provider=s counties in Missouri and compete for business, Interim would be obligated to protect the Provider=s rights as well.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - 42 U.S.C.:

' 1395x(v) et seq.	-	Reasonable Cost
' 1395f(b)	-	Amount Paid to Providers
' 1395l(a)	-	Amount of Payment

2. Regulations - 42 C.F.R.:

'' 405.1835.-1841	-	Board Jurisdiction
' 405.1853(a)	-	Prehearing Discovery and Other Proceedings Prior to the Board Hearing
' 413.9 et seq.	-	Cost Related to Patient Care
' 413.24(a)	-	Adequate Cost Data and Cost
' 413.102 et seq.	-	Compensation of Owners

3. Program Instructions-Provider Reimbursement Manual-Part I (HCFA-Pub.15-1):

' 110.A.2	-	Sale and Leaseback Agreements Rental Charges
' 902.3	-	Definitions-Reasonableness
' 904 et seq.	-	Criteria for Determining Reasonable Compensation
' 905.4	-	New Providers and Future Surveys
' 2113	-	Home Health Coordination (Or Home Care Intake Coordination) Costs-General

' 2113.1	-	Home Health Coordinator Activities
' 2113.2	-	Patient Solicitation Activities
' 2135 et seq.	-	Purchased Management and Administrative Support Services
' 2136 et seq.	-	Allowable Advertising Costs

4. Case Law:

Call-A-Nurse, [1999-2 Transfer Binder] Medicare & Medicaid Guide (CCH) & 300,325.

Stat Home Health Care, Inc. v. Blue Cross and Blue Shield Association, PRRB Dec. No. 96-D7, January 30, 1996, Medicare & Medicaid Guide (CCH) & 44,011, decl=d rev., HCFA Admin., March 15, 1996.

Interstate Circuit v. United States, 306 U.S. 208, 226 (1939).

International Union v. NLRB, 459 F.2d 1329, 1336 (D.C. Cir. 1972).

High Country Home Health, Inc. v. Shalala, [1999-1 Transfer Binder] Medicare & Medicaid Guide (CCH) & 300,173 (D. Wyo. 1999).

Transactive Corporation v. United States, 91 F.3d 232, 237 (D.C.Cir. 1996).

Cheshire Hospital v. New Hampshire-Vermont Hospitalization Service, Inc., 689 F.2d 1112, 1126 (1st Cir. 1982).

Home Health Concepts, Inc. v Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of South Carolina, PRRB Dec. No. 93-D58, July 19, 1993, Medicare and Medicaid Guide (CCH) & 41,607, decl=d rev., HCFA Admin., September 9, 1993.

Mother Francis Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Texas, PRRB Dec. No. 95-D16, January 11, 1995, Medicare and Medicaid Guide (ACCH@) & 43,037, rev=d., HCFA Admin., March 8, 1995, Medicare and Medicaid Guide (ACCH@) & 43,241.

Memorial Hospital/Adair City, 829 F.2d at 118.

GranCare, Inc., and Regency Health Services, Inc., v. Shalala, 93 F. Supp. 2d 24 (D.D.C. 2000).

Vermilion Home Health Agency, [1990 Transfer Binder] Medicare & Medicaid Guide (CCH) **&** 38,377 at 22,125.

Home Health Services of Greater Philadelphia, 530 F. Supp. at 1246 (E.D. Pa. 1982).

St. Joseph=s Hospital v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 83-D104, July 5, 1983, Medicare and Medicaid Guide (CCH) **&** 33,096, aff=d in part (concerning administrative fee issue), HCFA Admin., September 6, 1983, Medicare and Medicaid Guide (CCH) **&** 33,424.

Interim HealthCare of New Haven, PRRB Dec. No. 2000-D1, October 14, 1999, Medicare and Medicaid Guide (CCH) **&** 80,341, decl=d rev., HCFA Admin., November 30, 1999.

Hooper v. National Transportation Safety Board, 841 F.2d 1150 (D.C. Cir. 1988).

Garrett v. FCC, 513 F.2d 1056 (D.C. Cir. 1975).

Motor Vehicle Mfrs. Ass=n of U.S., Inc. v. State Farm Mutual Auto. Ins. Co, 463 U.S. 29, 57 (1983).

Greater Boston Television Corp. v. FCC, 444 F.2d 841, 852 (D.C. Cir. 1970), cert. denied, 403 U.S. 923 (1971).

Airmark Corp. v. FAA, 758 F.2d 685, 691-92 (D.C. Cir. 1985).

Local 777, Democratic Union 0rganization Committee v. NLRB, 603 F.2d 862, 872 (D.C. Cir. 1978).

5. Other:

Homecare Salary & Benefits Report 1996-1997

63 Fed. Reg. 5106 (January 30, 1998).

HCFA Letter, August 5, 1999.

Blue Cross and Blue Shield Association Administrative Bulletin No. 1401, 80.01.

Market Survey, The Corridor Group, Inc.

Black=s Law Dictionary 629, 668 (7th ed. 1999).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties= contentions, testimony elicited at the hearing, and post-hearing submissions, finds and concludes as follows:

ISSUE No. 1 - Owner=s Compensation

The Intermediary reduced the amount of owner=s compensation that would be allowed for program reimbursement in two ways. First, the Intermediary lowered the compensation amount from $115,398, as claimed by the Provider, to $107,494, which was derived from the Homecare Salary & Benefits Report 1996-1997. Next, the Intermediary prorated the $107,494 amount based upon the actual number of hours the subject owner worked at the Provider=s facility (954) in relationship to the total number of hours that he worked at all of the HHAs he is affiliated with (2,774). Subsequently, the Intermediary conceded that the $115,398 amount is reasonable for a full-time employee. Therefore, the only matter before the Board is the propriety of the proration of the subject compensation. The Board notes that there is no dispute over the number of hours worked by the owner at the Provider=s facility or the total number of hours worked at all facilities.

The Board finds that program instructions at HCFA Pub. 15-1 ' 904.2(C)(1) provide the rules for apportioning owner=s compensation where an individual works less that on a full-time basis. In part, the manual states:

> [c]ompensation for Afull-time@ service requires that at least 40 hours per week be devoted to the duties of the position for which compensation is requested. Owners devoting less than 40 hours per week to the position will be compensated on a proportionate basis, with 40 hours per week considered to be the full-time basis for such proportionate compensation.

HCFA Pub. 15-1 ' 904.2(C)(1).

Upon analysis, the Board finds that the Intermediary was correct to prorate the Provider=s owner=s compensation since it is clear that the subject individual worked less than 40 hours per week for the Provider. However, it was not correct for the Intermediary to base its proration upon total hours worked. Rather, the proration should be based upon 2,080 hours yielding allowable program costs of $52,928 (954 hours) 2,080 hours x $115,398).

The Board believes the manual instructions quoted above clearly intend for 2,080 hours to be the denominator in prorating owner=s compensation for part-time employment. That is, using 40 hours per week as stated in the manual (Apart-time employment with 40 hours per week considered to be the full-time basis for such proportionate compensation@) times 52 weeks. The Board finds this construction supported by the District Court in High Country Home Health, Inc. v. Shalala, [1999-1 Transfer

Binder] Medicare & Medicaid Guide (CCH) **&** 300,173 (D. Wyo. 1999), finding:

> [t]he intermediary improperly disallowed a portion of a home health agency=s claimed owner/administrator=s compensation. Section 904.2 of the Provider Reimbursement Manual states that an owner working on a part-time basis will be compensated on a proportionate basis and directs the intermediary to use 40 hours per week, or 2,080 hours per year, as the full-time basis for such proportionate compensation. Hence, the intermediary=s methodology, which used the total number of hours the owner actually worked (60 per week) as the full-time basis, was improper.

Id.

The Board rejects the Provider=s argument regarding the uniqueness of its situation, in that, its owner=s compensation was reduced to $30,000 in 1997, and to zero in the next two cost reporting periods. There is no evidence in the record to evaluate this argument, and the cost reporting periods referenced by the Provider are not before the Board.

ISSUE No. 2 - Community Liaison

The Board finds that the Provider claimed 100 percent of its Community Liaison costs in its 1996 cost reporting period, and that the Intermediary disallowed them. The basis of the Intermediary=s disallowance was inadequate Provider records and the Intermediary=s belief that at least part of the Community Liaison=s time was spent performing non-reimbursable activities geared toward patient solicitation.

The Provider, aware of Medicare=s rules about claiming costs that had previously been disallowed, reviewed its Community Liaison=s time records and determined that 19 percent of her time could possibly be construed as non-reimbursable pursuant to program rules. Accordingly, the Provider self-disallowed this percentage of its Community Liaison costs in its 1997 cost report. The Intermediary, however, still disallowed 100 percent of the costs that were claimed.[68]

Subsequent to the Intermediary=s disallowances, the Provider furnished a 12 week sample of the time records maintained by its Community Liaison during the Provider=s 1996 cost reporting period, and an 11 week sample of her time records maintained during 1997. The Intermediary reviewed this data and is now agreeable to allowing 18 percent of the Provider=s Community Liaison costs in 1996 and 15 percent in 1997.

The Board finds that the job description developed by the Provider for its Community Liaison position, as well as the coding system used by the Provider to record employee time, include both allowable and

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[68] Tr. at 177.

unallowable activities pursuant to HCFA Pub. 15-1 ' 2136.1 and ' 2136.2, allowable and unallowable advertising costs, and HCFA Pub. 15-1 ' 2113, home care coordination. Accordingly, the Board finds that the issue at hand is a matter of quantifying the allowable and unallowable portions of the Community Liaison=s time.

Respectively, the Board finds that the Intermediary=s proposal to disallow 82 percent of the Provider=s 1996 Community Liaison costs and 85 percent of its 1997 costs is improper.
The Board concludes that the most credible evidence in this case is the Provider=s review of its Community Liaison=s time records used to prepare its 1997 cost report. Essentially, the Board finds that the Intermediary=s review of the Provider=s time records is inharmonious and unreliable. The Provider=s review, however, is supported by the Board=s own examination of the subject time records.

With respect to the Intermediary=s review, the Board finds that the Intermediary identified seven activity codes that represent unallowable activities. These include code A200,@ a general classification designated as Community & Client Service Liaison Activities, and six subclassifications including codes 225, 230, 235, 240, 245, and 250. The problem, however, is that even though the Intermediary identified these specific codes as the basis for its disallowances, it summarily disallowed all time associated with the 200 code category, e.g., disallowing time charged to codes 215, 220, 270 and 280, which were not identified as unallowable activities.

The Board=s examination shows that the Community Liaison did use the 200 codes extensively, and that she included a narrative description of her activity along with each coded entry. However, these records do not make it apparent that the Community Liaison was performing unallowable activities regardless of the 200 code that was used. To the contrary, the Board notes that from January 27, 1997, through July 18, 1997, the Community Liaison used a time study form which enabled her to specifically identify her time with AGeneral@ operations or to AMedicare@ and ANon-Medicare@ functions. And, during this period, she charged all of her time to Medicare and attested to the accuracy of her time records.

The Board also notes an extreme weakness in the Intermediary=s fundamental concern that the Community Liaison was working to increase the Provider=s patient utilization. That is, the evidence in this case shows that the Provider=s patient utilization, both Medicare and in total, decreased significantly from 1996 through its 1997 cost reporting period.

In consideration of the facts, the Board concludes that 81 percent of the Provider=s Community Liaison costs, in both its 1996 and 1997 cost reports, are allowable. This conclusion applies the 19 percent self-disallowance determined by the Provider for its 1997 cost reporting period to the subject 1996 cost reporting period. The Board believes this application is prudent considering the same person was employed as the Community Liaison and, based upon a comparison of the entries in her 1996 and 1997 time studies, was doing the same job or performing the same types of activities.

ISSUE No. 3 - Franchise Fees

The Board finds that the Provider claimed $83,865 in expenses for weekly service fees paid to Interim, its franchisor. For cost reporting purposes, however, the Provider charged $31,088 of the service fees to its Medicare reimbursable A&G cost center, and the remaining $52,777 to a non-reimbursable cost center which is allocated only to the Provider=s non-reimbursable private duty and staffing services. As a result, the Intermediary=s adjustment allowing $32,160 of the total $83,865 paid to Interim has a reimbursement impact of approximately $16,500.

The Board finds that the Provider presented substantive evidence showing that its costs, which include the subject service fees, were reasonable. This evidence addresses the Provider=s total costs and its A&G cost per visit, as well as the franchise service fees themselves. Conversely, the Intermediary raised two concerns with respect to the Provider=s costs. First, the Intermediary asserts that the subject costs include payments for certain franchise rights such as the use of a logo, territory protection, or certain types of advertising that are unallowable. Second, the Intermediary asserts that the FMV of the services furnished by Interim does not support the costs claimed by the Provider, i.e., that the FMV of the services is significantly less than the Provider=s service fees.

Regarding the reasonableness of the Provider=s costs, the Board finds that the Provider presented substantive evidence showing that its A&G cost per visit, which as noted above includes the subject service fees, is lower than most other HHAs in its area. The data indicates that the Provider=s A&G cost per visit was approximately $22.70, whereas the median A&G cost per visit for 30 other HHAs in its area was $28. Also, the Provider presented data showing that its total costs were approximately $450,000 below the cost limits established by HCFA for the subject cost reporting period. In addition, the Provider presented data showing that the service fee it pays to Interim for management services is lower, as a percentage of revenues, than service fees paid by other HHAs in the same area. The Intermediary, however, did not present specific data that questioned the reasonableness of the Provider=s claimed cost as compared to other HHAs.

With respect to the Intermediary=s concern over franchise fees, or purchased management and support services, the Board finds that certain costs are clearly unallowable pursuant to HCFA Pub. 15-1 ' 2135.4. The Board notes, however, that the contract between the parties contains an initial franchise fee of $15,000. The Intermediary does not believe the Provider=s claim that this was the only fee attributable to non-allowable items and assumes that some of the weekly service fees must be attributable to them. The Board, however, finds no evidence in the record to support the Intermediary=s claim.

Regarding the FMV of the services rendered by Interim, the Board finds that the Intermediary=s analysis relied upon outdated values and hourly rates which resulted in an improper adjustment to the Provider=s costs. For example, the Intermediary valued Aoffsite support,@ which is only one of several categories of services furnished by Interim, at $26,000. The $26,000 amount was taken from BCBSA Administrative Bulletin # 1401, 80.01, that was issued in 1980 and based upon 2 hours of service per

day for a 260 day work year at $50.00 per hour. Clearly, there is no basis upon which to presume that the value of offsite support should remain stagnant for 17 years.

In opposition to this point, the Provider placed into evidence a recent study of Interim=s services conducted by The Corridor Group. In part, the study shows that the cost of consulting services ranged from $150 to $200 per hour during the subject period. Using this data and BCBSA=s methodology places the value of the Provider=s offsite support services between $78,000 and $104,000. The Board finds this prospect far more realistic than the $50 per hour rate and $26,000 value used by the Intermediary.

In summary, the Board finds no evidence in the record to substantiate that any of the subject costs are attributable to either franchise fees or other unallowable expenditures. Moreover, the Board finds that the Intermediary did not carry out a persuasive analysis of the FMV of the services rendered to the Provider. In viewing the FMV of the franchise services claimed by the Provider, even a conservative approach shows the value of those services exceeds the actual costs claimed. As discussed immediately above, the FMV of offsite services alone is reasonably set near or above the total cost claimed by the Provider, yet several other services need to be considered in the FMV determination in addition to a 20 percent add-on allowed by the Intermediary for intangible and standby services. Notably, the intermediary in New Haven set the FMV of Interim=s offsite support services at $91,000, with respect to a 1994 cost reporting period.

DECISION AND ORDER:

ISSUE No. 1- Owner=s Compensation

The Intermediary was correct to prorate the Provider=s owner=s compensation in order to determine allowable program costs. The proration, however, is to be based upon 2,080 hours rather than total hours. The Intermediary=s adjustment is modified.

ISSUE No. 2 - Community Liaison

The Intermediary=s adjustments disallowing the Provider=s claimed Community Liaison costs are improper. Eighty one (81) percent of the Provider=s Community Liaison costs are allowable in both the 1996 and 1997 cost reporting periods. The Intermediary=s adjustments are modified.

ISSUE No. 3 - Franchise Fees

The Intermediary=s adjustment disallowing the costs of the Provider=s weekly service fees was improper. The Intermediary=s adjustment is reversed.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esq.
Martin W. Hoover, Jr. Esq.
Charles R. Barker
Stanley J. Sokolove

Date of Decsion: April 17, 2001

FOR THE BOARD:

Irvin W. Kues
Chairman